LOUISIANA CONRAD STATE 30 PROGRAM QUARTERLY SERVICE REPORT FOR PARTICIPATING PHYSICIANS

Please mail or fax to: Jeanne R. Haupt
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628 North 4th Street Fax: (225) 342-5839
Baton Rouge, LA 70802 E-mail: Jeanne.Haupt@la.gov
Web site: *http://new.dhh.louisiana.gov/index.cfm/page/570/n/252*

Physician:	**Medicaid ID#**	**Start Work Date (date began working to complete J-1 waiver obligation):**
Home Address:	Practice Name/Address:	
Home Telephone Number:	Practice Telephone Number:	Practice Fax Number:

*Please update above information for any changes.

FOR SERVICES RENDERED FROM: _____TO:_____
(MM/YY) (MM/YY)

Number of **clinical (patient) hours** worked per quarter:	Total number of hours worked during quarter:
If hours less than expected (less than 40 hours per week, 32 clinical hours/wk), please explain:	
Patient Profile Statistics: Complete each item and indicate ACTUAL or ESTIMATED FOR THE PHYSICIAN AND THE TOTAL PRACTICE NUMBERS, e.g., 300/1000 (physician #/total practice #)	
# of total patients for the quarter: /	# Primary Care patients: /
# Specialty Care patients: /	# AIDS/HIV (if pertinent to approval): /
# Medicaid patients: /	# Medicare patients: /
# Un-/underinsured/self pay non-indigent: /	# Uninsured/underinsured indigent/SFS: /
# of HPSA residents treated (if in non-designated area): / Which HPSAs (ID#s)?	
Is the sign/notification of patients about the availability of the sliding scale/indigent policy in place? YES/NO If no, note date of correction for this deficiency: _____	

Complete on your last report: Are you staying at this practice site? If no, where do you plan to go? Please provide contact information if you plan to leave.

I verify that the physician named has maintained a full-time practice at the facility listed and that all medical practice has been provided in the appropriate designated HPSA(s).

Physicians Signature:	Employer's Signature/Title:
Date:	Date:
DHH Use:	Date Received: Date Entered: